Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2004 Survey: VAH Hines, IL - 578 and VA Chicago HCS (VAMC Chicago (LS) - 537A4 and VAMC Chicago (WS) - 537)

VISN 12

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 1529

2. Point-in-time estimate of Veterans who are Chronically Homeless: 393

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **1529** (point-in-time estimate of homeless veterans in service area) **X 29%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 87%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 393** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	2144	31
Transitional Housing Beds	1713	290
Permanent Housing Beds	3616	450

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Transitional living facility	Partner with community agencies on grant submissions (e.g., HUD, VA Grant and Per Diem). Maintain VA representation on key community boards, task forces, coalitions. Continue partnership with Illinois Dept. of Veterans Affairs, Veterans Benefits Administration and Veteran Centers in addressing needs of homeless veterans.
Long-term, permanent housing	Partner with community agencies on grant submissions (e.g., HUD, VA Grant and Per Diem. Maintain VA representation on key community boards, task forces, coalitions. Continue partnership with Illinois Dept. of Veterans Affairs, VBA and Veteran Centers in addressing needs of homeless veterans.
Help with finding a job or getting employment	Improve networking by VA with Disabled Veterans Outreach Programs, community employment resources and employers, and education and training resources.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 23 Non-VA staff Participants: 52%
Homeless/Formerly Homeless: 0%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Long-term, permanent housing	1.77	62%	2.25	1
2	Child care	2	0%	2.39	3
3	Legal assistance	2.09	0%	2.61	4
4	Halfway house or transitional living facility	2.23	48%	2.76	8
5	Dental care	2.23	5%	2.34	2
6	Job training	2.29	5%	2.88	14
7	Discharge upgrade	2.36	0%	2.90	15
8	Eye care	2.5	0%	2.65	5
9	Glasses	2.5	0%	2.67	6
10	Spiritual	2.52	5%	3.30	27
11	Help managing money	2.55	5%	2.71	7
12	Help with finding a job or getting employment	2.57	14%	3.00	17
13	Guardianship (financial)	2.59	5%	2.76	9
14	Drop-in center or day program	2.64	0%	2.77	10
15	SSI/SSD process	2.71	5%	3.02	19
16	Help with transportation	2.71	0%	2.82	11
17	Personal hygiene (shower, haircut, etc.)	2.76	0%	3.21	26
18	Education	2.77	0%	2.88	13
19	Women's health care	2.86	5%	3.09	21
20	Food	2.9	0%	3.56	35
21	Emergency (immediate) shelter	2.91	14%	3.04	20
22	Detoxification from substances	2.91	0%	3.11	22
23	Family counseling	2.91	0%	2.85	12
24	Treatment for dual diagnosis	2.95	0%	3.01	18
25	Welfare payments	2.95	5%	2.97	16
26	Clothing	3.05	0%	3.40	31
27	Help getting needed documents or identification	3.05	0%	3.16	23
28	Treatment for substance abuse	3.09	5%	3.30	28
29	AIDS/HIV testing/counseling	3.09	5%	3.38	30
30	Services for emotional or psychiatric problems	3.14	5%	3.20	25
31	Help with medication	3.14	0%	3.18	24
32	Hepatitis C testing	3.32	0%	3.41	32
33	VA disability/pension	3.36	5%	3.33	29
34	Medical services	3.38	0%	3.55	34
35	TB treatment	3.45	0%	3.45	33
36	TB testing	3.59	0%	3.58	36

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.43	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	2.91	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	4.04	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4.04	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	4	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	3.87	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.83	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.91	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.92	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	2.33	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.25	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.75	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.64	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	2	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2.17	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.5	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.83	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	2	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.64	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.82	1.84

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2004 Survey: VAH Madison, WI - 607

VISN 12

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 209

2. Point-in-time estimate of Veterans who are Chronically Homeless: 57

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **209** (point-in-time estimate of homeless veterans in service area) **X 29%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 95%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 57** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	297	0
Transitional Housing Beds	288	0
Permanent Housing Beds	413	169

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 2

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Once again, our #1 need is for long-term, permanent housing. Section 8 housing vouchers continue to be on hold. Local homeless coalition agencies will continue the search for funds and properties for permanent housing development. We will continue to interact regularly with these groups to ensure that homeless veterans have access to this housing.
Transitional living facility	Will continue to outreach to Madison, Rockford, and Freeport as well as to other catchment areas where homeless veterans appear to be underserved in order to give information about and make referrals to our VA Grant and Per Diem programs.
Dental Care	Our dental care program served 17 homeless veterans this past year through VA Dental Service and through an agreement with the Wautoma Dental Clinic. Whether or not this need is met in the year to come appears to be totally dependent on funding dedicated for these services.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 23 Non-VA staff Participants: 57%
Homeless/Formerly Homeless: 4%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Eye care	2.23	0%	2.65	5
2	Long-term, permanent housing	2.27	35%	2.25	1
3	Glasses	2.27	13%	2.67	6
4	Help managing money	2.27	0%	2.71	7
5	Dental care	2.3	22%	2.34	2
6	Child care	2.3	0%	2.39	3
7	Legal assistance	2.55	4%	2.61	4
8	Drop-in center or day program	2.59	0%	2.77	10
9	Education	2.67	4%	2.88	13
10	Halfway house or transitional living facility	2.77	26%	2.76	8
11	SSI/SSD process	2.77	0%	3.02	19
12	Welfare payments	2.81	9%	2.97	16
13	Family counseling	2.86	0%	2.85	12
14	Job training	2.86	17%	2.88	14
15	Help with transportation	2.86	0%	2.82	11
16	Guardianship (financial)	2.95	0%	2.76	9
17	Personal hygiene (shower, haircut, etc.)	3	0%	3.21	26
18	Spiritual	3.11	0%	3.30	27
19	Emergency (immediate) shelter	3.18	30%	3.04	20
20	Help with finding a job or getting employment	3.23	9%	3.00	17
21	Help with medication	3.27	4%	3.18	24
22	Discharge upgrade	3.44	0%	2.90	15
23	Treatment for dual diagnosis	3.45	9%	3.01	18
24	AIDS/HIV testing/counseling	3.48	0%	3.38	30
25	VA disability/pension	3.48	4%	3.33	29
26	Clothing	3.52	0%	3.40	31
27	Detoxification from substances	3.52	4%	3.11	22
28	Women's health care	3.52	0%	3.09	21
29	Help getting needed documents or identification	3.53	0%	3.16	23
30	Food	3.57	0%	3.56	35
31	Treatment for substance abuse	3.65	4%	3.30	28
32	Hepatitis C testing	3.67	0%	3.41	32
33	TB treatment	3.68	0%	3.45	33
34	Services for emotional or psychiatric problems	3.7	4%	3.20	25
35	Medical services	3.7	0%	3.55	34
36	TB testing	3.77	0%	3.58	36

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	4.04	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.65	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	4.22	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4.3	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	4.13	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	3.95	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	4	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.87	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.54	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	2.57	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.93	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.38	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.69	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.54	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.15	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.62	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.15	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.27	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.58	1.84

Prepared by John Nakashima, Ph.D., MSW
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CHALENG 2004 Survey: VAMC Iron Mountain, MI - 585

VISN 12

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 3

2. Point-in-time estimate of Veterans who are Chronically Homeless: 1

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **3** (point-in-time estimate of homeless veterans in service area) **X 25%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 89%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 1** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	20	0
Transitional Housing Beds	15	0
Permanent Housing Beds	10	0

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Immediate shelter	Improved communications regarding services available. Develop MOAs with local shelters.
Long-term, permanent housing	Improve communication regarding services available with housing commission, housing assistance program, and local landlords. Develop informal work agreements with them.
VA disability/pension	Improve communications regarding services available. Develop a closer working relationship with Veterans Service officers.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 19 Non-VA staff Participants: 95%
Homeless/Formerly Homeless: 0%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Dental care	2.27	23%	2.34	2
2	Education	2.38	8%	2.88	13
3	Legal assistance	2.38	0%	2.61	4
4	Drop-in center or day program	2.43	0%	2.77	10
5	Child care	2.46	0%	2.39	3
6	Long-term, permanent housing	2.47	31%	2.25	1
7	Glasses	2.53	8%	2.67	6
8	Eye care	2.6	0%	2.65	5
9	Halfway house or transitional living facility	2.71	15%	2.76	8
10	Help with medication	2.71	0%	3.18	24
11	Discharge upgrade	2.77	0%	2.90	15
12	SSI/SSD process	2.79	8%	3.02	19
13	Help with transportation	2.85	0%	2.82	11
14	Welfare payments	2.93	0%	2.97	16
15	Personal hygiene (shower, haircut, etc.)	3	0%	3.21	26
16	TB treatment	3	0%	3.45	33
17	Job training	3	15%	2.88	14
18	Help with finding a job or getting employment	3	15%	3.00	17
19	Help getting needed documents or identification	3	0%	3.16	23
20	Emergency (immediate) shelter	3.07	23%	3.04	20
21	Services for emotional or psychiatric problems	3.07	15%	3.20	25
22	Treatment for dual diagnosis	3.07	0%	3.01	18
23	TB testing	3.07	0%	3.58	36
24	Clothing	3.13	8%	3.40	31
25	Family counseling	3.14	0%	2.85	12
26	Spiritual	3.17	8%	3.30	27
27	Detoxification from substances	3.21	0%	3.11	22
28	Women's health care	3.21	0%	3.09	21
29	Guardianship (financial)	3.23	0%	2.76	9
30	Food	3.27	15%	3.56	35
31	Medical services	3.29	0%	3.55	34
32	VA disability/pension	3.29	8%	3.33	29
33	Help managing money	3.31	0%	2.71	7
34	AIDS/HIV testing/counseling	3.36	0%	3.38	30
35	Treatment for substance abuse	3.5	0%	3.30	28
36	Hepatitis C testing	3.6	8%	3.41	32

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.65	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	2.88	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	3.82	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	3.53	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	3.53	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	3.56	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.47	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.47	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.19	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	1.94	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.8	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	1.94	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.44	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.5	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2.06	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.63	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.69	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.6	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.6	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.53	1.84

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CHALENG 2004 Survey: VAMC Milwaukee, WI - 695

VISN 12

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 216

2. Point-in-time estimate of Veterans who are Chronically Homeless: 48

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **216** (point-in-time estimate of homeless veterans in service area) **X 26%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 87%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 48** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	871	0
Transitional Housing Beds	385	144
Permanent Housing Beds	340	334

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Milwaukee: Seek to establish additional partnerships with state, local and not-for-profit entities to create more permanent housing opportunities for veterans. Racine: Through Homeless Assistance Coalition of Racine, identify additional resources for shelter care.
Job Training	Milwaukee: Increase referrals to CWT and local job assistance programs. Racine: Work with collaborating agency to increase availability of HVRP resources to needy and eligible veterans.
Treatment for Dual Diagnosis	Increase access to VISN and VA programs for dual diagnosis treatment.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 61 Non-VA staff Participants: 70%
Homeless/Formerly Homeless: 11%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Long-term, permanent housing	2.2	37%	2.25	1
2	Dental care	2.33	8%	2.34	2
3	Eye care	2.46	4%	2.65	5
4	Welfare payments	2.6	0%	2.97	16
5	Child care	2.6	0%	2.39	3
6	Drop-in center or day program	2.63	2%	2.77	10
7	Glasses	2.63	0%	2.67	6
8	Emergency (immediate) shelter	2.66	19%	3.04	20
9	Help with transportation	2.67	4%	2.82	11
10	Halfway house or transitional living facility	2.7	13%	2.76	8
11	Guardianship (financial)	2.74	2%	2.76	9
12	Treatment for dual diagnosis	2.75	15%	3.01	18
13	SSI/SSD process	2.75	2%	3.02	19
14	Help with medication	2.78	0%	3.18	24
15	Hepatitis C testing	2.81	0%	3.41	32
16	Legal assistance	2.83	2%	2.61	4
17	Treatment for substance abuse	2.84	19%	3.30	28
18	Job training	2.85	10%	2.88	14
19	Help managing money	2.86	6%	2.71	7
20	Detoxification from substances	2.91	2%	3.11	22
21	Women's health care	2.91	0%	3.09	21
22	TB treatment	2.91	0%	3.45	33
23	Discharge upgrade	2.92	0%	2.90	15
24	Family counseling	2.94	2%	2.85	12
25	Help with finding a job or getting employment	2.95	10%	3.00	17
26	Education	2.96	13%	2.88	13
27	Help getting needed documents or identification	2.98	2%	3.16	23
28	AIDS/HIV testing/counseling	3.04	0%	3.38	30
29	Services for emotional or psychiatric problems	3.09	8%	3.20	25
30	TB testing	3.09	2%	3.58	36
31	VA disability/pension	3.11	2%	3.33	29
32	Medical services	3.13	2%	3.55	34
33	Personal hygiene (shower, haircut, etc.)	3.22	0%	3.21	26
34	Clothing	3.25	0%	3.40	31
35	Spiritual	3.29	2%	3.30	27
36	Food	3.33	13%	3.56	35

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.44	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.19	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	3.97	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4.12	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	3.88	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	3.8	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.64	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.58	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.65	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	2.23	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.08	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.6	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	2	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.96	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.98	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.44	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.9	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.96	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	2.08	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.02	1.84

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2004 Survey: VAMC North Chicago, IL - 556

VISN 12

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 211

2. Point-in-time estimate of Veterans who are Chronically Homeless: <DATA NOT AVAILABLE>

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **211** (point-in-time estimate of homeless veterans in service area) **X <DATA NOT AVAILABLE>%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X <DATA NOT AVAILABLE>%** (percentage of veterans served who had a mental health or substance abuse disorder) **= <DATA NOT AVAILABLE>** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	101	37
Transitional Housing Beds	311	15
Permanent Housing Beds	100	43

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	A new application for 15 Shelter Plus Care beds has been submitted to HUD with Shields Township as sponsor, and North Chicago VAMC as one participating organization. PADS Crisis Services may be adding units for families in the coming year. Additionally, developer will be encouraged to build affordable housing. Information regarding funding and loan opportunities will be provided through Lake County Coalition for Homeless.
Help with Transportation	This issue will be discussed to obtain possible solutions through the Lake County Coalition for the Homeless and the Lake County Continuum of Care. Possible solutions include the Share-a-Ride program of the local transit authority and attempts to encourage agencies to develop a van program. VAMC North Chicago vocational program will also discuss issue with employers.
Transitional living facility	Technical assistance and support will be given to agencies seeking funding for transitional living facilities, especially for the special needs population and families.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 18 Non-VA staff Participants: 89%
Homeless/Formerly Homeless: 6%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Long-term, permanent housing	2.18	44%	2.25	1
2	Help with transportation	2.53	6%	2.82	11
3	Child care	2.63	11%	2.39	3
4	Halfway house or transitional living facility	2.71	28%	2.76	8
5	Emergency (immediate) shelter	2.76	11%	3.04	20
6	Discharge upgrade	2.8	0%	2.90	15
7	Legal assistance	2.89	0%	2.61	4
8	Family counseling	3	0%	2.85	12
9	Job training	3	0%	2.88	14
10	Personal hygiene (shower, haircut, etc.)	3.06	0%	3.21	26
11	Help managing money	3.06	0%	2.71	7
12	Help with finding a job or getting employment	3.06	0%	3.00	17
13	Education	3.07	6%	2.88	13
14	Help getting needed documents or identification	3.11	0%	3.16	23
15	Welfare payments	3.19	0%	2.97	16
16	Spiritual	3.22	0%	3.30	27
17	Dental care	3.28	11%	2.34	2
18	Drop-in center or day program	3.31	0%	2.77	10
19	SSI/SSD process	3.31	0%	3.02	19
20	Treatment for dual diagnosis	3.33	6%	3.01	18
21	Guardianship (financial)	3.33	0%	2.76	9
22	Food	3.44	11%	3.56	35
23	Detoxification from substances	3.44	6%	3.11	22
24	Clothing	3.5	6%	3.40	31
25	Women's health care	3.5	22%	3.09	21
26	Help with medication	3.53	0%	3.18	24
27	Treatment for substance abuse	3.56	6%	3.30	28
28	AIDS/HIV testing/counseling	3.65	0%	3.38	30
29	Eye care	3.67	0%	2.65	5
30	VA disability/pension	3.69	0%	3.33	29
31	Services for emotional or psychiatric problems	3.78	6%	3.20	25
32	Glasses	3.78	0%	2.67	6
33	TB treatment	3.82	0%	3.45	33
34	Hepatitis C testing	3.88	0%	3.41	32
35	TB testing	3.94	0%	3.58	36
36	Medical services	4.06	11%	3.55	34

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.72	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.22	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	3.76	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4.06	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	3.87	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	3.94	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.6	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.6	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	1.53	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.33	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.27	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.47	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.2	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.43	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.27	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.53	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.4	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.4	1.84

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CHALENG 2004 Survey: VAMC Tomah, WI - 676

VISN 12

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 560

2. Point-in-time estimate of Veterans who are Chronically Homeless: 161

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **560** (point-in-time estimate of homeless veterans in service area) **X 34%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 84%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 161** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	120	70
Transitional Housing Beds	164	75
Permanent Housing Beds	135	35

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Help with Transportation	Encourage and assist with development as a collaborative effort so as to share costs. Look at grant writing opportunities for vehicles and operating costs. Develop volunteer driver programs.
Long-term, permanent housing	Attend local planning council meeting to educate and inform on findings of local survey on the need for improved access and new permanent housing. Educate local housing program on advance discharge planning so veterans return to county of referral. Re-establish landlord/tenant association group.
Help with finding a job or getting employment	Work with local homeless program which received grant to assist veterans with obtaining employment. Educate VA staffs on this grant and assist homeless program with referrals as indicated. Involve community in referral process and education.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 17 Non-VA staff Participants: 100%
Homeless/Formerly Homeless: 0%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Dental care	2.12	6%	2.34	2
2	Long-term, permanent housing	2.24	29%	2.25	1
3	Child care	2.24	0%	2.39	3
4	Help with transportation	2.29	47%	2.82	11
5	Drop-in center or day program	2.38	0%	2.77	10
6	Legal assistance	2.41	0%	2.61	4
7	Eye care	2.71	0%	2.65	5
8	Welfare payments	2.76	0%	2.97	16
9	Glasses	2.82	0%	2.67	6
10	Family counseling	2.88	0%	2.85	12
11	Education	2.88	0%	2.88	13
12	Help managing money	2.94	0%	2.71	7
13	Halfway house or transitional living facility	3	18%	2.76	8
14	Detoxification from substances	3	6%	3.11	22
15	Guardianship (financial)	3	6%	2.76	9
16	Job training	3	6%	2.88	14
17	SSI/SSD process	3.06	0%	3.02	19
18	Help with finding a job or getting employment	3.06	24%	3.00	17
19	Discharge upgrade	3.06	0%	2.90	15
20	Spiritual	3.07	0%	3.30	27
21	Personal hygiene (shower, haircut, etc.)	3.12	0%	3.21	26
22	Emergency (immediate) shelter	3.12	24%	3.04	20
23	AIDS/HIV testing/counseling	3.12	0%	3.38	30
24	Treatment for dual diagnosis	3.18	0%	3.01	18
25	TB treatment	3.18	0%	3.45	33
26	Treatment for substance abuse	3.24	0%	3.30	28
27	Help getting needed documents or identification	3.24	0%	3.16	23
28	Clothing	3.25	0%	3.40	31
29	Services for emotional or psychiatric problems	3.29	6%	3.20	25
30	TB testing	3.35	0%	3.58	36
31	Women's health care	3.41	0%	3.09	21
32	Food	3.47	12%	3.56	35
33	Help with medication	3.47	0%	3.18	24
34	Hepatitis C testing	3.59	0%	3.41	32
35	VA disability/pension	3.65	12%	3.33	29
36	Medical services	3.69	0%	3.55	34

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.47	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.24	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	3.82	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	3.94	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	3.88	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	3.76	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.35	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.41	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.56	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	2	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.35	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.29	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.65	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.59	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.82	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.24	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.75	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.82	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.82	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.94	1.84